

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore *2d*

## CERTIFICATE OF DEATH

Reg. Dist. No.

1830

9448

1. PLACE OF DEATH:  
 County *Harpers*  
 City or town *White Hall, Md. Rural*

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 3. (a) FULL NAME

*Andrew Lemmon Anderson*4. Sex *Male* 5. Color or race *white* 6. (a) Single, married, widowed, or divorced *married*6. (b) Name of husband or wife *Wallace Johnson*7. Birth date of deceased (mo., day, yr.) *Aug. 7, 1858* 8. (c) If alive, give age *96* years8. AGE: Years *88* Months *0* Days *25* If less than one day hrs. min.9. Birthplace *Harpers Co* (Town, county, and state)10. Usual occupation *Retail merchant Farmer*

11. Industry or business

12. Name *Wallace Johnson*13. Birthplace *Baltimore Co Md*14. Maiden name *Elizabeth Lemmon*15. Birthplace *Harpers Co.*16. Informant *Mr. J. Ross Wiley*Address *White Hall Md.*17. Burial *Buried* Date thereof *Sept 4 1946* (Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory *Bethel*Location *White Hall, RFD*18. Funeral director *Harold S. Franklin*Address *White Hall Md*

19. Sept 4 1946 Thomas R Brown

(Date rec'd by registrar)

2. USUAL RESIDENCE (HOME) OF DECEASED:  
 (For newborn infants give residence of mother)

State *Ind* County *Harpers*City or town *Blank House* (If outside city or town limits, write RURAL and give nearest town)

Street No. \_\_\_\_\_ (If rural, give LOCATION)

2.(a) If veteran, name war \_\_\_\_\_

3. (b) Social Security Number *Node*

## MEDICAL CERTIFICATION

20. DATE OF DEATH *Sep 4 1946* 1946 at 12:00 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

1940 to 1946, to *Sep 4 1946* 1946and that I last saw him alive on *Sep 4 1946* 1946

Immediate cause of death \_\_\_\_\_

DURATION *2 days*Due to *coronary thrombosis*Due to *valvular heart disease*

Other conditions \_\_\_\_\_

(Include pregnancy within 3 months of death)

Major findings or operations \_\_\_\_\_

Date of op. \_\_\_\_\_

Autopsy results \_\_\_\_\_

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work \_\_\_\_\_

23. SIGNATURE *Wm. Bostick M.D.*

M.D. or other \_\_\_\_\_

Address *White Hall* Date signed *Sep 4 1946*

RECEIVED

DEC 24 1946

BUREAU V-8

2 - 35

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 20

09050

182

## CERTIFICATE OF DEATH

Reg. Dist. No.

## 1. PLACE OF DEATH:

County

City or town

*Harford  
White Hall Rural*

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 3. (a) FULL NAME

*Emma Anderson*

5. Color or race

6. (a) Single, married, widowed, or divorced

Female

Married

Hispit

Walter Anderson

6. (b) Name of husband or wife

Alive

7. Birth date of

deceased (mo., day, yr.)

8. AGE:

Years

Months

Day

It less than one day

49

No

4

hrs.

min.

*Sept. 6, 1897*9. Birthplace: *Grayson Co., Va.*  
(Town, County, and state)

10. Usual occupation:

*House work*

11. Industry or business:

*at Home*

FATHER

12. Name: *Charles Jennings*

MOTHER

13. Birthplace: *Grayson Co., Va.*14. Maiden name: *Matilda Hampton*15. Birthplace: *Grayson Co., Va.*16. Informant: *Walter Anderson*Address: *White Hall, Md.*17. Burial: *Acre Burial*

(Burial, cremation, or removal, which?)

Cemetery or crematory: *Mt. Zion Cem.*Location: *Harford Co., Md.*18. Funeral director: *J. S. Bailey*Address: *Arlington, Mass.*19. Date rec'd by registrar: *9/10 1946*

(Date received by registrar)

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: *MD*City or town: *Whitewall*

(If outside city or town limits, write RURAL and give nearest town)

Street No.: *no*

(If rural, give LOCATION)

2.(a) If veteran, name war: *no*3. (b) Social Security Number: *no*

## MEDICAL CERTIFICATION

20. DATE OF DEATH: *September 10, 1946, at 4:10 AM*21. I CERTIFY that death occurred on the date above stated: that I attended deceased from *July 10, 1945, to Sept. 10, 1946*, and that I last saw her alive on *Sept. 9, 1946*.Immediate cause of death: *Metastatic carcinoma*Duration: *14 yrs.*Due to: *Carcinoma of Left Breast*Due to: *3 yrs.*Other conditions: 

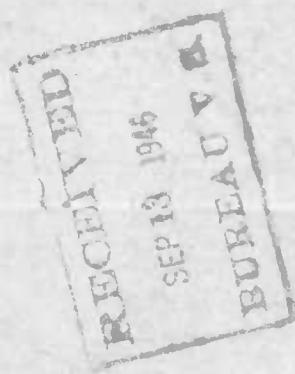
(Include pregnancy within 8 months of death)

Major findings or operations: *Pregnancy in Left Breast Lump*Date of op: *April, 1943*Autopsy results: *None*

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, list in the following:

Accident, suicide, or homicide:  Date of: Where did injury occur?  (City or town)  (County)  (State)Injured at home, farm, industry, public place (where?): Means of Injury:  Injured at work? 23. SIGNATURE: *Charles A. Neff MD.*Address: *Street, Md.* D.O. or other: Date signed: *9-10-46*



14  
15  
16

PLEASE WRITE PLAINLY,  
WITH UNFADING INK. Supply every item of information carefully. The correct age  
is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 73d

## CERTIFICATE OF DEATH

09051

182

Reg. Dist. No.

## 1. PLACE OF DEATH:

County.....

*Hartford*

City or town.....

*Creswell Rd*

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?.....*50 years*

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 3. (a) FULL NAME

*Annie Elizabeth*

4. Sex

*F**w*

5. Color or race

*M*

6. (a) Single, married, widowed, or divorced

*Robt Beatty*

6. (b) Name of husband or wife.....

6. (c) If alive, give age.....*86* years

7. Birth date of deceased (mo., day, yr.)

*Unknown*

8. AGE:

Years

Months

Days

If less than one day

88

hrs.

min.

9. Birthplace.....

*Baltimore, Md*

(Town, county, and state)

10. Usual occupation.....

*Home wife*

11. Industry or business

*Warren*

FATHER

*Balt., Md*

MOTHER

*UNKNOWN*

14. Maiden name.....

*UNKNOWN*

15. Birthplace.....

*UNKNOWN*

16. Informant.....

*Robt. Beatty*

Address

*Bellair man*

17. Burial.....

*Burial*

Date thereof.....

*Sept 26/46*

(month) (day) (year)

Cemetery or crematory.....

*Mt. Zion*

Location.....

*Fontana Green Hartford Co., Md*

18. Funeral director.....

*Dean & Foster*

Address

*Bellair man*

19. Date rec'd by registrar.....

*9/25**1946**Priscilla Lowman*

Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State.....*Md*County.....*Hartford*City or town.....*Creswell*Rural.....*Rural*

Street No.....

(If rural, give LOCATION)

2.(a) If veteran, name war.....

*Beatty*

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

20. DATE OF DEATH.....

*23 SEPTEMBER 1946* at *7:15 P.M.*21. I CERTIFY that death occurred on the date above stated; that I attended deceased from  
*6 Sept.* 1946, to *23 Sept.* 1946and that I last saw her *alive* on *23 Sept.* 1946Immediate cause of death.....*CEREBRAL HEMORRHAGE*

DURATION

*3 DAYS*Due to.....*HYPERTENSIVE CARDIO - VASCULAR DISEASE*

over 10 yrs

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide.....

Date of.....

Where did injury occur?.....

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?).....

Means of injury.....

Injured at work?

23. SIGNATURE.....

*Robert A. Beatty MD*

M. D. or other

Address.....

*Forest Hill, Md.*Date signed *9/24/46*

RECOLLECTION

SEP 28 1946

BUREAU V.8

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

UPPER CORPORATION LIMITED CO.

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 19

09052

## CERTIFICATE OF DEATH

Reg. Dist. No. 185

### 1. PLACE OF DEATH:

County Hanover

City or town Hanover Md.

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? about 8 yrs.

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

### 3. (a) FULL NAME

Jay Byrd

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Male

Negro

Married

Loris Byrd

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.)

July 22 - 1905

6. (c) If alive, give age years

8. AGE:

Years

Months

Days

If less than one day

41

1

15

hrs.

min.

9. Birthplace

Charleston South Carolina

(Town, county, and state)

10. Usual occupation

Distillery Mechanic

11. Industry or business

Ben Byrd

12. Name

Newbury Co. S.C.

13. Birthplace

Markenby Town

14. Maiden name

Markenby Town

15. Birthplace

Markenby Co. S.C.

16. Informant

Mrs. Loris Byrd (wife)

Address 519 S. Stokes

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof 9/12/46 (month) (day) (year)

Cemetery or crematory

Beaverton

Location Hanover Co. D.C.

18. Funeral director

Pennington & Son

Address Hanover Grace Md.

19. Sept. 8 1946

(Date rec'd by registrar)

A. H. Lewis M.D.

Registrar

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland

County Hanover

City or town Hanover Md.

(If outside city or town limits, write RURAL and give nearest town)

Street No. 519 S. Stokes

(If rural, give LOCATION)

2.(a) If veteran, name war

### 3. (b) Social Security Number

### MEDICAL CERTIFICATION

20. DATE OF DEATH

Sept 7

1946 at

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

7-10-1946 to 9-7-1946

and that I last saw him alive on

9-7-1946

Immediate cause of death

Acute myocarditis

9-7-46

Due to

Acute Pleurisy

7-18-46

Due to

Acute Pleurisy

7-10-46

Other conditions

Pneumonia

7-10-46

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Pauline L. Brown M.D.

M. D. or other

Address Hanover Grace Md.

Date signed Sept 8 1946

RECEIVED

SEP 10 1945

BUREAU V.E.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 51-9

## CERTIFICATE OF DEATH

Reg. Dist. No. 123-090525

## 1. PLACE OF DEATH:

County.....  
City or town.....  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?.....  
3 daysHospital, institution, or street address where death occurred:  
Harford Memorial HospitalHow long in hospital or institution?.....  
3 days

## 3. (a) FULL NAME

JOSEPH B. CARLISLE

## 3. (b) Social Security Number

## 4. Sex

Male | white | married  
5. Color or race

(a) Single, married, widowed, or divorced

6. (b) Name of husband or wife.....  
Eliz. D. Carlisle7. Birth date of deceased (mo., day, yr.).....  
April 30, 1871

8. (c) If alive, give age..... 65 years

8. AGE: Years Months Days If less than one day  
75 5 6 - hrs. - min.9. Birthplace.....  
(Town, county, and state) Maryland10. Usual occupation.....  
Farmer11. Industry or business.....  
Retired12. Name.....  
William Carlisle13. Birthplace.....  
Del.14. Maiden name.....  
Sara Peterson15. Birthplace.....  
Md.16. Informant.....  
Elizabeth D. CarlisleAddress.....  
Aberdeen Maryland #117. Burial.....  
(Burial, cremation, or removal. Which?)  
Date thereof.....  
(month) (day) (year)  
Sept. 9 1946Cemetery or crematory.....  
Mt. ZionLocation.....  
Harford Co. Md.18. Funeral director.....  
J. Madison MitchellAddress.....  
Aire de Grace Md.19. (Date rec'd by registrar).....  
9-9 1946 A.D. Lewis M.D.  
Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... Maryland County..... Harford

City or town..... Aberdeen Rural  
(If outside city or town limits, write RURAL and give nearest town)Street No..... Bush Chapel Rd #1  
(If rural, give LOCATION)

2.(a) If veteran, name war.....

## MEDICAL CERTIFICATION

20. DATE OF DEATH..... Sept. 6 1946 at 10:30 P.M.

21. I CERTIFY that death occurred on the date above listed; that I attended deceased from Sept. 5 1946 to Sept. 6 1946 and that I last saw him alive on Sept. 6 1946.

Immediate cause of death.....

Cardio-Vascular Collapse 4 day

Due to..... Hemorrhage

Due to..... Cancer of prostate

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations..... Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury..... Injured at work?

23. SIGNATURE..... Dudley &amp; Sullivan M.D. M. D. or other

Address..... Harford Memorial Hosp. Date signed 9-6-46

RECEIVED

SEP 10 1946

FAU V

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 832

## CERTIFICATE OF DEATH

09054 185  
Reg. Dist. No.

## I. PLACE OF DEATH:

County Maryland

City or town Hanover

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 6 yrs.

Hospital, Institution or street address where death occurred:

St. Francis Villa

How long in hospital or institution? 6 yrs.

## 3. (a) FULL NAME

Lester Mary Plautilla (Catherine Casey)

## 3. (b) Social Security Number

4. Sex

5. Color of hair

6. (a) Single, married, widowed, or divorced

Female

White

Single

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.)

August 15 - 1877

8. AGE:

Years Months Days If less than one day

69

1

0

hrs.

min.

9. Birthplace

Ireland

(Town, county, and state)

10. Usual occupation

Nurse

11. Industry or business

Charles Casey

12. Name

Ireland

13. Birthplace

Mary Philius

14. Maiden name

Ireland

15. Birthplace

Holy Records

16. Informant

Hanover

Address

Burial

Date thereof 9/18/46

(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Holy Redeemer

Location Baltimore, Md.

Pennington &amp; Bow

18. Funeral director

Hanover

Address

Dept. 12 1946

(Date rec'd by registrar)

G. L. Lewis M.D.

Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Hanford

City or town Hanover

(If outside city or town limits, write RURAL and give nearest town)

Street No. Commerce &amp; Market

(If rural, give LOCATION)

2.(a) If veteran, name war

## MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 15 1946 at 7 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

James 19 1946 to Sept 15 1946

and that I last saw him alive on Sept 15 1946

Immediate cause of death

Ostium Ileum

Intestinal Obstruction

Due to External Hemorrhage

Due to

Other conditions

Toxemia

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

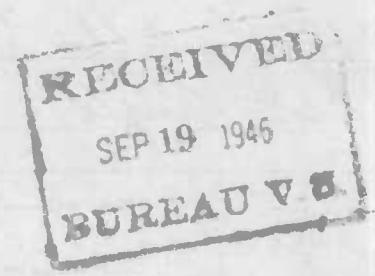
Means of injury

Injured at work?

23. SIGNATURE

Charles J. Tolson M.D. or other

Address Hanover Date 9/17/46



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 940

09055

## CERTIFICATE OF DEATH

Reg. Dist. No. 182

## 1. PLACE OF DEATH:

County

Harford

City or town

Mountaint Green

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

25 years

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

## 3. (a) FULL NAME

Roberta Coomes

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Female

White

married

Mitchel Coomes

6. (b) Name of husband

Alive

7. Birth date of deceased (mo., day, yr.)

deceased (mo., day, yr.)

March 13, 1866

years

months

days

If less than one day

hrs.

min.

KODAK FILM

SEP 28 1946

BUREAU OF

Evidence of age  
birth date of deceased is shown  
FILM NO. I 07 OCT 8 1946 MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 470

69056

Reg. Dist. No. 186-

CERTIFICATE OF DEATH

1. PLACE OF DEATH:

County.....

Harford State Md.

City or town.....

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?.....

3 wks.

Hospital, institution, or street address where death occurred:

Harford Memorial Hospital

How long in hospital or institution?.....

3 wks.

3. (a) FULL NAME

Mattie Masletta Culver

4. Sex

Female

5. Color or race

White

6.(a) Single, married, widowed, or divorced

Widowed

6.(b) Name of husband or wife

Rudolph Culver

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

July 4, 1884

November 26,

8. AGE:

Years

Months

Days

If less than one day

57

2

23.

hrs.

min.

9. Birthplace

Baltimore City Md.

(Town, county, and state)

10. Usual occupation

Housewife

11. Industry or business

William Bell

MOTHER FATHER

12. Name

William Bell

13. Birthplace

Baltimore Co. Md.

MOTHER FATHER

14. Maiden name

Mary Anna Russell

15. Birthplace

Baltimore City Md.

MOTHER FATHER

16. Informant

Myron S. Fuole

Address

Bel Air Md.

17. Burial

Date thereof Sept 6, 1946

(Burial, cremation, or removal. Which?)

(month) (day) (year)

Cemetery or crematory

Bakus Cemetery

Location

New Aberdeen Rd.

18. Funeral director

Turing & Sons

Address

Aberdeen Md.

19. Date rec'd by registrar

Sept. 5 1946

VS A15 9-45

A. L. Lewis M.D.

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Harford

City or town Bel Air Rd 2

(If outside city or town limits, write RURAL and give nearest town)

Street No. at Harford Furnace Md.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

2D. DATE OF DEATH

Sept 2 1946 at 7:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Jan 1 1946 to Sept 2 1946

and that I last saw her alive on Sept 2 1946

Immediate cause of death

Paroxysm of

night sweats

Due to

Annual Cerebral

Due to

Toxins

Other conditions

Diabetes

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE

Charles J. Foley M.D.

M. D. or other

Address

Date signed



**PLEASE WRITE PLAINLY, WITH UNFADING INK.** Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

09057

**CERTIFICATE OF DEATH**

Reg. Dist. No. 185-

1. PLACE OF DEATH: County..... City or town..... (If outside city or town limits, write RURAL and give nearest town)			2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother) State..... County..... City or town..... (If outside city or town limits, write RURAL and give nearest town)		
How long in above place of death? Hospital, institution, or street address where death occurred: <i>617 So. Washington St.</i>			Street No. <i>617 So. Washington St.</i> (If rural, give LOCATION)		
How long in hospital or institution?			2.(a) If veteran, name war.		
3. (a) FULL NAME <i>Willard Hammond Day</i>			3. (b) Social Security Number <i>217-16-1553</i>		
4. Sex <i>Male</i>	5. Color or race <i>White</i>	6.(a) Single, married, widowed, or divorced <i>Married</i>	MEDICAL CERTIFICATION		
6.(b) Name of husband or wife <i>Blanche P. Day</i>			20. DATE OF DEATH <i>Sept. 17 1946</i>		
7. Birth date of deceased (mo., day, yr.) <i>Aug. 17 1893</i>			21. I CERTIFY that death occurred on the date above stated; that I attended deceased from <i>June 1946</i> to <i>Sept. 17 1946</i> and that I last saw him alive on <i>Sept. 17 1946</i>		
8. AGE: Years <i>53</i> Months <i>1</i> Days <i>0</i> less than one day			Immediate cause of death <i>Arterio Venous Cerebral Hemorrhage</i>		
9. Birthplace..... (Town, county, and state) <i>Navre de Grace Md.</i>			Due to <i>Hypertension</i>		
10. Usual occupation..... <i>Cust. Cashier</i>			Due to <i>Cardiac Failure</i>		
11. Industry or business..... <i>First Natl. Bank Wdkt.</i>			Other conditions..... (Include pregnancy within 3 months of death)		
12. Name..... <i>Wm F Day</i>			Major findings of operations..... Date of op.		
13. Birthplace..... <i>Md.</i>			Autopsy results.....		
14. Maiden name..... <i>Mary Hammond</i>			PHYSICIAN: Please underline the cause to which death should be charged statistically.		
15. Birthplace..... <i>Md.</i>			22. VIOLENCE: if death was due to external causes, fill in the following:		
16. Informant..... <i>Mrs. Blanche P. Day</i>			Accident, suicide, or homicide..... Date of.....		
Address <i>617 So. Washington St. City.</i>			Where did injury occur?..... (City or town)..... (County)..... (State).....		
17. Burial..... (Burial, cremation, or removal. Which?) <i>Buried</i>			Injured at home, farm, industry, public place (where?).....		
Cemetery or crematory..... <i>Congel's Hill</i>			Means of injury..... Injured at work?		
Location..... <i>Navre de Grace Md.</i>			23. SIGNATURE..... M. D. or other.....		
18. Funeral director..... <i>R. Madison Mitchell</i>			Address..... Date signed.....		
Address..... <i>Navre de Grace Md.</i>					
19. Death 19 46 (Date rec'd by registrar)					
Registrar.....					



## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 1950

## CERTIFICATE OF DEATH

09058

182

Reg. Dist. No. 182

## 1. PLACE OF DEATH:

County... Hartford

City or town... Forest Hill (Rural)

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1/2 hr.

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 3. (a) FULL NAME

GERALDINE ELLIS

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

F

W

S

6. (b) Name of husband or wife:

7. Birth date of

deceased (mo., day, yr.)

6. (c) If alive, give age..... years

Sept 4/1946

8. AGE:

Years

Months

Days

If less than one day

14

hrs.

min.

9. Birthplace... Forest Hill Md

(Town, county, and state)

10. Usual occupation:

11. Industry or business

Sam Hoyer Ellis

12. Name

MOTHER FATHER

13. Birthplace

N.C.

14. Maiden name

Edna Church

15. Birthplace

NC

16. Informant

Mrs Edna C Ellis

Address

Forest Hill Md

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof Sept 19/46

(month) (day) (year)

Cemetery or crematory

Sharon Baptist C

Location

Sharon, Md. Rural

18. Funeral director

Dean &amp; Lister

Address

Bel Air, Md

19. Date rec'd by registrar

19

9/19 46

Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... Md

County...

Hartford

City or town... Forest Hill (Rural)

(If outside city or town limits, write RURAL and give nearest town)

Street No....

(If rural, give LOCATION)

2.(a) If veteran, name war...

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 18

1946, at 4 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

18..., to...

18...

and that I last saw h...

alive on

Immediate cause of death... ASPHYXIA TONIC

DURATION

Due to... PREMATURE DUE TO  
ASPIRATION OF FEEDING

Due to...

Other conditions...

(Include pregnancy within 8 months of death)

Major findings or operations...

Date of op.

Autopsy results...

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide...

Date of...

Where did injury occur? ... (City or town) ... (County) ... (State)

Injured at home, farm, industry, public place (where?)...

Means of Injury

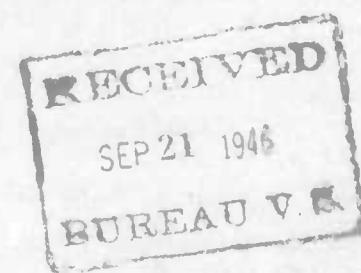
Injured at work?

23. SIGNATURE

J.W. Hansen, M.D.  
Dep. medical Examiner  
M.D. of Maryland

Address... Aberdeen, Md.

Date signed... 9/18/46



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

939

## CERTIFICATE OF DEATH

Reg. Dist. No.

09050  
182

1. PLACE OF DEATH: Hartford  
 County.....  
 City or town..... E.M. Morton  
(If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 23 years  
 Hospital, institution, or street address where death occurred:  
 \_\_\_\_\_  
 How long in hospital or institution? \_\_\_\_\_

3. (a) FULL NAME James H Ely  
 4. Sex m 5. Color or race w 6. (a) Single, married, widowed, or divorced  
 6. (b) Name of husband or wife Sarah N Bond  
 7. Birth date of deceased (mo. day. yr.) Jany 17 - 1864 6. (c) If alive, give age ..... years  
 8. AGE: Years 82 Months \_\_\_\_\_ Days \_\_\_\_\_ If less than one day  
 hrs. \_\_\_\_\_ min. \_\_\_\_\_  
 9. Birthplace Hartford Co. Md  
(Town, county, and state)  
 10. Usual occupation Farmer  
 11. Industry or business  
 FATHER 12. Name John Ely Ely  
 MOTHER 13. Birthplace Md  
 14. Maiden name Hannah Tucker  
 15. Birthplace Md  
 16. Informant Mr S Nellie Morsook  
 Address Bel Air Md, RD 2  
 17. Burial Calvary, Methodist  
(Burial, cremation, or removal. Which?) Date thoroot Sept 18 / 1946  
(month) (day) (year)  
 Cemetery or crematory Calvary, Methodist  
 Location Hartford Co. Md.  
 18. Funeral director Dean & Foster  
 Address Bel Air Md  
 19. 9/18 1946 Piscilla Louvold  
(Date rec'd by registrar) Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:  
(For newborn infants give residence of mother)  
 State Md County Hartford  
 City or town E.M. Morton Rural  
(If outside city or town limits, write RURAL and give nearest town)  
 Street No. \_\_\_\_\_  
(If rural, give LOCATION)  
 2.(a) If veteran, name war. \_\_\_\_\_

3. (b) Social Security Number

## MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 16 1946 at 11:30 AM  
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from  
2-7 1946 to 9-16 1946  
 and that I last saw him alive on Sept 15 1946

Immediate cause of death  
coronary occlusion

DURATION  
2 wks

Due to arterial sclerosis  
myocarditis

10 yrs

Duo to.

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results.

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

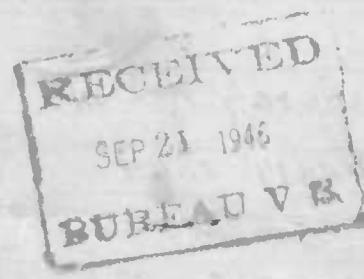
Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of Injury

Injured at work?

23. SIGNATURE Fred O Hodous M. D. or other  
 Address Edgewater Md Date signed 9-16-46



## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 83

09060

## CERTIFICATE OF DEATH

Reg. Dist. No.

182

## 1. PLACE OF DEATH:

County

Harford

City or town

Forest Hill

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

10 days

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 3. (a) FULL NAME

Pauline A. Grafton

## 3. (b) Social Security Number

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Female white

Single

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.)

6. (c) If alive, give age years

Jan 4 1891

8. AGE:

Years

Months

Days

If less than one day

55

8

21

hrs.

min.

9. Birthplace

Forest Hill Harford County

(Town, county, and state)

10. Usual occupation

P.O. X Operator

11. Industry or business

Sales Lady

12. Name

A. Duran Grafton

13. Birthplace

Forest Hill Md.

14. Maiden name

Elizabeth Kean

15. Birthplace

Forest Hill Md.

16. Informant

Mr Fred R Tucker

Address

Forest Hill Md.

17. Burial

Date thereof Sept 27 46

(Burial, cremation, or removal. Which?)

(month) (day) (year)

Cemetery or crematory

Rock Spring

Location

Forest Hill Md.

18. Funeral director

Martin Gruen

Address

Jarretsville Md.

19. Date rec'd by registrar

9/26/46

19.

Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

County

Md Baltimore City

(If outside city or town limits, write RURAL and give nearest town)

Street No. 2907 Fieldale Drive

(If rural, give LOCATION)

2.(a) If veteran, name war

## MEDICAL CERTIFICATION

2D. DATE OF DEATH September 25

1946 at 7:55 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from September 16

1946 to Sept. 25

and that I last saw her alive on September 24

1946

Immediate cause of death

Broncho Pneumonia

1 day

Due to Cerebral Embolism

3 months

Due to Auricular Fibrillation

about 20 year

due to probably rheumatic fever

unknown

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

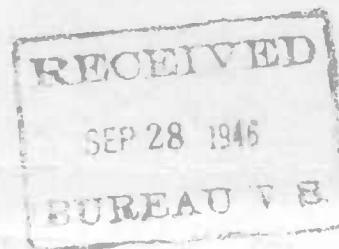
Means of injury Injured at work?

23. SIGNATURE

Robert A. Bartholomew MD

M. D. or other

Address Forest Hill, Maryland Date signed 9/25/46



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

WITHIN CORPORATE LIMITS OF

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 32

09061

## CERTIFICATE OF DEATH

Reg. Dist. No. 185-

## 1. PLACE OF DEATH:

County

City or town

Harford

Havre de Grace

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

12 yrs

Hospital, Institution, or street address where death occurred:

Ontario St. Extended

How long in hospital or institution?

## 3. (a) FULL NAME

Martha Elizabeth Heuse

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Female

White

Widowed

6. (b) Name of husband or wife

T. Clifton Heuse

7. Birth date of deceased (mo., day, yr.)

Nov. 29, 1867

6. (c) If alive, give age - years

8. AGE:

Years

Months

Days

If less than one day

—

—

hrs.

— min.

8. Birthplace

Baltimore

(Town, county, and state)

10. Usual occupation

House Wife

11. Industry or business

John N. Fine

FATHER

12. Name

John N. Fine

MOTHER

13. Birthplace

Penn.

14. Maiden name

Rachel P. Gerbruck

15. Birthplace

Md.

16. Informant

Mrs. G. N. Thompson

Address

Ontario St. Ext. City

Burial

Sept. 27, 1946

Date thereof

(month) (day) (year)

(Burial, cremation, or removal, Which?)

Engel Bell

Cemetery or crematory

Havre de Grace, Md.

Location

R. Madison Mitchell

18. Funeral director

Havre de Grace, Md.

Address

19. Sept. 27

1946

(Date rec'd by registrar)

A. L. Lewis

Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

Md.

County

Harford

City or town

Havre de Grace

(If outside city or town limits, write RURAL and give nearest town)

Street No.

Ontario St. Extended

(If rural, give LOCATION)

2. (a) If veteran, name war

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

20. DATE OF DEATH

Sept. 24, 1946

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Jan. 7, 1946, to Sept. 24, 1946,

and that I last saw her alive on Sept. 24, 1946

Immediate cause of death

Acute Delirious Agitatemus

DURATION

Due to

Cerebral Hemorrhage

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Charles Foley

Md.

W. D. or other

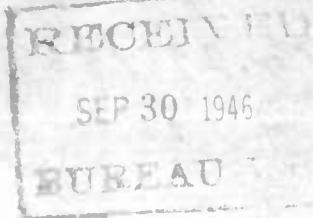
Signature

Date signed

Address

Havre de Grace

Date signed



## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 148-2

09062

## CERTIFICATE OF DEATH

Reg. Dist. No.

185-

## 1. PLACE OF DEATH:

County HagerstownCity or town Hagerstown, Md.

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 dayHospital, Institution, or street address where death occurred: Hagerstown Memorial HospitalHow long in hospital or institution? 1 day

## 3. (a) FULL NAME

Amy Howell

## 4. Sex

F

## 5. Color or race

W

## 6. (a) Single, married, widowed, or divorced

M

6. (b) Name of husband or wife.....

Levi L. Howell

28

7. Birth date of deceased (mo., day, yr.) Mar. 15, 1915

6. (c) If alive, give age..... years

8. AGE: Years 31 Months 5 Days 20 If less than one day

hrs. .... min.

9. Birthplace Kentucky

(Town, county, and state)

10. Usual occupation Housewife11. Industry or business None12. Name Garland J. Howell13. Birthplace Kentucky14. Maiden name Amy Robinson15. Birthplace Kentucky16. Informant Levi L. & F. HowellAddress Liberty Grove, Cecil Co., Md.17. Removal Removal

(Burial, cremation, or removal; Which?)

Date thereof Sept. 7 1946

(month (day) (year))

Cemetery or crematory Pike Co. Ky.Location Pike Co., Kentucky18. Funeral director J. Madison MitchellAddress Havre de Grace, Md.19. Sept. 5 - 1946

(Date rec'd by registrar)

Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md.County CecilCity or town Rural. Liberty Grove

(If outside city or town limits, write RURAL and give nearest town)

Street No. 1

(If rural, give LOCATION)

2.(a) Is veteran, name war.....

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

20. DATE OF DEATH

Sept. 4 1946 at 3:00 p.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Sept. 4 1946 to Sept. 4 1946, and that I last saw her alive on Sept. 4 1946.

Immediate cause of death.....

Edema

Due to.....

Pregnancy

Due to.....

Delivery

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings or operations.....

Date of op. ....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? ..... (City or town) ..... (County) ..... (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury..... Injured at work?

23. SIGNATURE Dudley Shirley, M.D.

M.D. or other

Address Hagerstown, Md.Date signed Sept. 4 1946

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

SEP 7 1946

BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 750

09063

## CERTIFICATE OF DEATH

Reg. Dist. No. 185-

## 1. PLACE OF DEATH:

County

City or town

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

85 yrs 10 mo. 17 days

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 3. (a) FULL NAME

Lillian de Moss Kennedy

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Female

White

Widow

## 6. (b) Name of husband or wife

Tho. H. Kennedy (dec.)

## 7. Birth date of deceased (mo., day, yr.)

10/19/1860

6. (c) If alive, give age years

## 8. AGE:

Years      Months      Days      If less than one day  
85      10      17      hrs.      min.

## 9. Birthplace

T. H. de Grace

(Town, county, and state)

## 10. Usual occupation

House wife

## 11. Industry or business

Dennis Malone

## 12. Name

Pennsylvania

## 13. Birthplace

Anne Reese

## 14. Maiden name

Pennsylvania

## 15. Birthplace

Mrs. William Foster

## 16. Informant

524 S. Washington

## Address

Burial

(Burial, cremation, or removal. Which?)

Date thereof... 9/2/46

(month) (day) (year)

## Cemetery or crematory

Angel Hill

## Location

T. H. de Grace

## 18. Funeral director

Pennytown &amp; Son

## Address

T. H. de Grace

Sept. 8 1946

(Date rec'd by registrar)

A. L. Lewis M.D.

Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

Maryland

County

Harford

City or town

T. H. de Grace

(If outside city or town limits, write RURAL and give nearest town)

Street No.

524 S. Washington

(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

## 20. DATE OF DEATH

9-6

1946 at 11<sup>10</sup> P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Dec. 4 1942 to 9-6 1946

and that I first saw her alive on 9-6 1946

## Immediate cause of death

Cardiac insufficiency

## Due to

Senility

## Due to

## Other conditions

(Include pregnancy within 8 months of death)

## Major findings of operations

Date of op.

## Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

## 22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide.

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

## Means of injury

Injured at work?

## 23. SIGNATURE

A. L. Lewis M.D.

M. D. or other

Address

T. H. de Grace M.D.

Date signed 9-8-46

RECEIVED

SEP 10 1946

BUREAU V.E.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 93-0

## CERTIFICATE OF DEATH

Reg. Dist. No. 090682

## 1. PLACE OF DEATH:

County HarfordCity or town Bell Air (rural)

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 4 months

Hospital, institution, or street address where death occurred:

Harford Convalescent Home

How long in hospital or institution?

## 3. (a) FULL NAME

Martha Ann Kirkwood4. Sex F.5. Color or race White6. (a) Single, married, widowed, or divorced Married6. (b) Name of husband or wife James T. H. Kirkwood6. (c) If alive, give age 78 years

7. Birth date of deceased (mo., day, yr.)

Oct 12, 18688. AGE: Years 77 Months 10 Days 27 If less than one day

hrs. .... min. ....

9. Birthplace Harford County, Maryland

(Town, county, and state)

10. Usual occupation Housewife

11. Industry or business

12. Name John McComas13. Birthplace Harford County14. Maiden name Mary Long15. Birthplace Harford County16. Informant Mr. Bushrod R. ShattoAddress 100 Yorkleigh Rd. Towson17. Burial Buried Date thereof Sept 21. 46

(Burial, cremation, or removal. Which?)

Cemetery or crematory BethelLocation Madonna Harford County, Md.18. Funeral director Martin G. KuryAddress Jarretsville, Md.19. 9/10 1946 Priscilla Lowood

(Date rec'd by registrar)

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md.County HarfordCity or town Rural - Bell Air

(If outside city or town limits, write RURAL and give nearest town)

Street No. Harford Convalescent Home

(If rural, give LOCATION)

2.(a) If veteran, name war.....

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 9

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

May 9 1946 to Sept 9 1946and that I last saw her alive on Sept 9 1946

Immediate cause of death

Acute Myocardial Disease

DURATION

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of .....

Where did injury occur? ..... (City or town) ..... (County) ..... (State)

Injured at home, farm, industry, public place (where?)

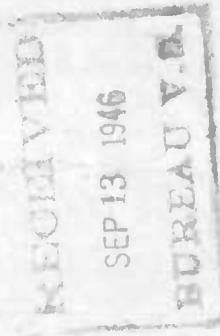
Means of injury

Injured at work?

23. SIGNATURE Weillard P. Hudson

M. D. or other

Address Forest Hill Md. Date signed 9/9/46



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

09065

## CERTIFICATE OF DEATH

Reg. Dist. No. **182**

1. PLACE OF DEATH: Harford  
County: Arlington  
City or town: Harington (If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death? 82 years  
Hospital, institution, or street address where death occurred:  
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:  
(For newborn infants give residence of mother)

State: Md County: Harford  
City or town: Arlington (If outside city or town limits, write RURAL and give nearest town)  
Street No.: 705 (If rural, give LOCATION)

## 3. (a) FULL NAME

May A. Knight4. Sex: Female 5. Color or race: White 6. (a) Single, married, widowed, or divorced: Married6. (b) Name of husband or wife: Geo. A. Knight 6. (c) If alive, give age: 82 years7. Birth date of deceased (mo., day, yr.): May 29, 18648. AGE: Years: 82 Months: 3 Days: 20 If less than one day:  hrs:  min: 9. Birthplace: Harford Co., Md. (Town, county, and state)10. Usual occupation: Housewife11. Industry or business: At Home12. Name: Bennett Hopkins13. Birthplace: Harford Co., Md.14. Maiden name: Darahn E. Morris15. Birthplace: Harford Co., Md.16. Informant: Mr. Geo. A. KnightAddress: Darlington, Md.17. Burial: Rock Ann Cem. Date thereof: Sept 13 1946 (Burial, cremation, or removal of remains?)Cemetery or crematory: Rock Ann Cem.Location: Harford Co., Md.18. Funeral director: H. S. BaileyAddress: Darlington, Md.19. (Date rec'd by registrar) Sept 11, 1946 M. D. or other M. H. Kirk

Registrar

## 3. (b) Social Security Number

705

## MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept. 10 19 46 at 3 P.M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 14 19 45 to Sept 10 19 46, fo.and that I last saw her alive on Sept 10 19 46.

Immediate cause of death:

Chronic nephritis 2 yrs  
Chronic Ulceratives 2 yrs

Due to:

Due to: -

Other conditions: -

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

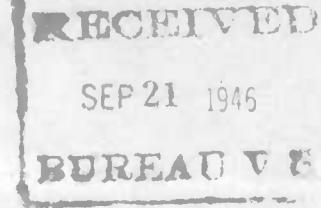
Accident, suicide, or homicide..... Date of.....

Where did injury occur? ..... (City or town) ..... (County) ..... (State)

Injured at home, farm, industry, public place (where?) .....

Means of Injury ..... Injured at work? .....

23. SIGNATURE: L. H. Snodgrass M. D. or other M. H. KirkAddress: Darlington, Md. Date signed Sept 11, 1946



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

CITY AND CORPORATE LIMITS OF

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 23

09066

## CERTIFICATE OF DEATH

Reg. Dist. No....

185

## 1. PLACE OF DEATH:

County.....

Harford

City or town.....

Harford Share

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?.....

1 day

Hospital, Institution, or street address where death occurred:

Harford Memorial Hosp

How long in hospital or institution?.....

1 day

## 3. (a) FULL NAME

Leoma La Rue

4. Sex

5. Color or race

6.(a) Single, married, widowed, or divorced

Female Colored 26 colored

6.(b) Name of husband or wife.....

Wm. L. La Rue

7. Birth date of

deceased (mo., day, yr.)

March 2 1893

6.(c) If alive, give age ..... years

8. AGE:

Years

Months

Days

If less than one day

53 6 18 hrs. min.

9. Birthplace.....

Port Deposit Md.

(Town, county, and state)

10. Usual occupation.....

Janitor

11. Industry or business

William McMullen

12. Name

Clara Mc Mullen

Pennsville Md.

13. Birthplace

14. Maiden name.....

Clara Mc Mullen

15. Birthplace.....

Clara Mc Mullen

16. Informant.....

Port Deposit Md.

Address.....

Port Deposit Md.

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof.....

(month) (day) (year)

Cemetery or crematory.....

Cokesbury

Location.....

Port Deposit Md.

18. Funeral director.....

A. L. Lewis

Address.....

Port Deposit Md.

19. Date rec'd by registrar.....

Sept. 20 1946

A. L. Lewis M.D.

Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants, give residence of mother)

State.....

Md.

County.....

Cecil Co.

City or town.....

Port Deposit Md.

(If outside city or town limits, write RURAL and give nearest town)

Street No.....

(If rural, give LOCATION)

2.(a) If veteran, name war.....

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

20. DATE OF DEATH.....

9-19

1946, at 5:20 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

9-19

1946, to

9-19 1946.

and that I last saw her alive on

9-19

1946.

Immediate cause of death.....

Cerebral Vasculon Hemorrhage.

DURATION

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?).....

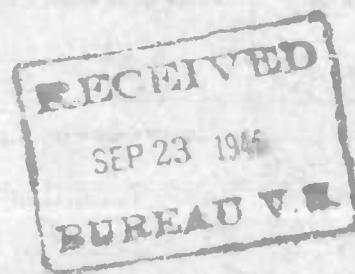
Means of injury.....

Injured at work?

23. SIGNATURE.....

M. D. or other

Address..... Port Deposit Md. Date signed. Sept. 20 1946



Evidence for the name is  
shown on

G108 12/10/46

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 97

CERTIFICATE OF DEATH

Reg. Dist. No. 182

9451

1. PLACE OF DEATH:

County.....

City or town.....

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?.....

Hospital, institution, or street address where death occurred:.....

How long in hospital or institution?.....

3. (a) FULL NAME

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

6. (b) Name of husband or wife.....

7. Birth date of deceased (mo., day, yr.).....

6. (c) If alive, give age..... years

8. AGE: Years \_\_\_\_\_ Months \_\_\_\_\_ Days \_\_\_\_\_

If less than one day

hrs. \_\_\_\_\_ min. \_\_\_\_\_

9. Birthplace.....

(Town, county, and state)

10. Usual occupation.....

Ted.  
Retired Farmer

11. Industry or business

MOTHER FATHER 12. Name.....

13. Birthplace.....

14. Maiden name.....

15. Birthplace.....

16. Informant.....

Address.....

17. Burial.....

(Burial, cremation, or removal. Which?)

Date thereof.....  
(month) (day) (year)

Cemetery or crematory.....

Location.....

18. Funeral director.....

Address.....

19. (Date rec'd by registrar).....

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State.....

City or town.....

Street No.....

2. (a) If veteran, name war.....

3. (b) Social Security Number

LYNCH

MEDICAL CERTIFICATION

20. DATE OF DEATH

September 8<sup>th</sup> 1946 at 1:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 1946 to September 8<sup>th</sup> 1946, and that I last saw him alive on September 3, 1946.

Immediate cause of death.....

uraemia, coma, two days.

Due to: urinary suppression - kidney dysfunction

Due to: Berillit 48 hours.

Due to: arteriosclerosis.

Other conditions: arteritis, scleritis

(Include pregnancy within 3 months of death)

Major findings of operations: \_\_\_\_\_ Date of op. \_\_\_\_\_

Autopsy results.

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

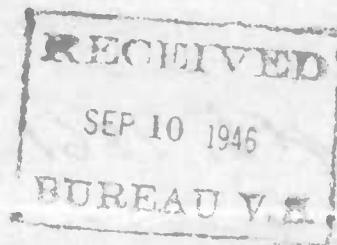
Means of injury..... Injured at work?

23. SIGNATURE

W. M. Shilling M.D. M. D. or other

Address..... Date signed 9/6/46

8  
1931  
9/6/



## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore *11-2*

09067

## CERTIFICATE OF DEATH

Reg. Dist. No.

185-

1. PLACE OF DEATH: *Harford*  
 County .....  
 City or town .....  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death?  
 Hospital, Institution, or street address where death occurred:  
*811 N. Adams, St.*

2. USUAL RESIDENCE (HOME) OF DECEASED:  
 (For newborn infants give residence of mother)

State ..... *Md.* County .....  
 City or town .....  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. *811 N. Adams, St.* (If rural, give LOCATION)

How long in hospital or institution?

2.(a) If veteran, name war.....

## 3. (a) FULL NAME

*Mary Monk*

## 3. (b) Social Security Number

4. Sex *Female* 5. Color or race *Black* 6. (a) Single, married, widowed, or divorced  
*Widowed*  
*Isaac Monk*

6. (b) Name of husband or wife.....

6. (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.)  
*Apr. 26, 1881*8. AGE: Years *65* Months *4* Days *27* If less than one day  
 hrs. ..... min.9. Birthplace *Harford Co. Md.*  
 (Town, county, and state)10. Usual occupation *House Duties*

11. Industry or business

12. Name *Geo. Cox*  
 FATHER *Md.*  
 13. Birthplace14. Maiden name *Mary Frances Cox*  
 MOTHER *Md.*  
 15. Birthplace16. Informant *Mrs. E. Stella Dyson*  
 Address *811 N. Adams, St. City.*17. Burial *Saran Creek*  
 (Burial, cremation, or removal. Which?) *Date thereof Sept. 25 1946*  
 Cemetery or crematory *Saran Creek*Location *Harford Co.*18. Funeral director *P. Madison Mitchell*  
 Address *Harde Grace Md.*19. *Sept. 25-1946* (Date rec'd by registrar) *G. L. Lewis M.D.*  
 Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH *Sept. 23, 1946*

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

*Aug. 1 1946* to *Sept. 22, 1946*  
 and that I last saw her alive on *Sept. 22, 1946*

Immediate cause of death.....

*Chronic Parenchymal Disease* *8-1-46*

Due to.....

*Arterio sclerosis* *1945-*

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury..... Injured at work?

23. SIGNATURES *Clarence L. Lawrence M.D.*  
 M. D. or otherAddress *Harde Grace* Date signed *Sept. 24-46*



## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

117-2

## CERTIFICATE OF DEATH

09068

Reg. Dist. No.

181

## 1. PLACE OF DEATH:

County Harford

City or town Aberdeen Proving Ground, Maryland  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 4½ years

Hospital, institution, or street address where death occurred:

Station Hospital, Aberdeen Proving Ground, Maryland

How long in hospital or institution? 2 Days

## 3. (a) FULL NAME

Captain Andrew B. C. Nicholls, O-910 850

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

Male White Married

6. (b) Name of deceased wife Marjorie (Wife)

7. Birth date of deceased (mo., day, yr.) 26 August 1910 8. (c) If alive, give age years

8. AGE: Years Months Days If less than one day  
36 0 11 hrs. min.9. Birthplace Tuscaloosa, Alabama  
(Town, county, and state)

10. Usual occupation Officer - U. S. Army

## 11. Industry or business

12. Name George J. Nicholls

13. Birthplace Foster, Alabama

14. Maiden name Ellen J. Smith Nicholls

15. Birthplace Mobile, Alabama

16. Informant Mrs. Marjorie Nicholls (Wife)

Address 130 Rogers St., Aberdeen, Md.

17. Transportation Date thereof Sept. 9, 1946  
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Jones &amp; Spigner Funeral Home

Location Tuscaloosa Ala.,

18. Funeral director Howard K. McComas &amp; Son

Address Abingdon Md.

19. Sept 12 1946 Nellie H. Riley  
(Date rec'd by registrar)

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Harford

City or town Aberdeen  
(If outside city or town limits, write RURAL and give nearest town)Street No. 130 Rogers Street  
(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

20. DATE OF DEATH 7 September 1946 at 2 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 4 September 1946 to 7 September 1946

and that I last saw him alive on 7 September 1946

Immediate cause of death Peritonitis

DURATION 20 hours

Due to Perforated Posterior Duodenal

Ulcer

Due to Chronic Posterior Duodenal

Ulcer

Other conditions None

DURATION 20 hours

DURATION 4 Years

(Include pregnancy within 3 months of death)

Major findings of operations None

Date of op.

Autopsy results Peritonitis &amp; Perf. Duodenal Ulcer

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Sidney Brenner M.D. or other

SIDNEY BRENNER, Capt., MC

Address Date signed

I Certify that I have received the remains of the above in good condition.



7189 AF

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 1226

09069

## CERTIFICATE OF DEATH

Reg. Dist. No. 181

## 1. PLACE OF DEATH:

County..... Hanford  
City or town..... Near Aberdeen

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 year

Hospital, Institution, or street address where death occurred:

Near Bush Chapel Road - RFD #1

How long in hospital or institution?

## 3. (a) FULL NAME

JOSEPH Raymond OSBORNE4. Sex Male 5. Color or race Colored 6.(a) Single, married, widowed, or divorced Single

6.(b) Name of husband or wife.....

7. Birth date of deceased (mo., day, yr.) Sept. 1916 19458. AGE: Years 1 Months  Days 7 If less than one day  hrs.  min. 9. Birthplace Near Aberdeen Hanford Co. Md.  
(Town, county, and state)10. Usual occupation None11. Industry or business None12. Name Ernest Butler13. Birthplace Gulchonow14. Maiden name Mabel Osborne15. Birthplace Abingdon16. Informant Mabel OsborneAddress Aberdeen, Md. P.D.17. Burial Date thereof Sept. 28 1946  
(Burial, cremation, or removal, Which?) Date thereof (month) (day) (year)Cemetery or crematory Mt CalvaryLocation Near Aberdeen18. Funeral director Henry TarringtonAddress Aberdeen, Md19. Sept. 28 1946  
(Date rec'd by registrar) Nellie D. Riley  
Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County HanfordCity or town Near Aberdeen (If outside city or town limits, write RURAL and give nearest town)Street No. Bush Chapel (If rural, give LOCATION)2.(a) If veteran, name war None

## 3. (b) Social Security Number

None

## MEDICAL CERTIFICATION APPROX

20. DATE OF DEATH SEPT 26, 1946 al. 6 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19..... to..... 19.....

and that I last saw h..... alive on..... 19.....

Immediate cause of death

TOXEMIA due to  
Intestinal obstruction

Due to.....

Due to.....

Other conditions malnutrition

(Include pregnancy within 3 months of death)

Major findings or operations None

Date of op. ....

Autopsy results None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

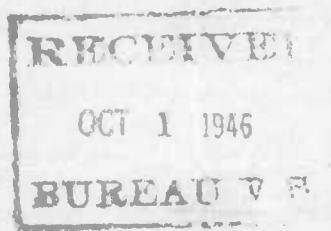
Where did injury occur? ..... (City or town) ..... (County) ..... (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury .....

Injured at work? .....

23. SIGNATURE J. H. Lawrence M.D.Dep. Medical ExaminerAddress Aberdeen, Md Date signed 9/26/46



09070

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dlat. No. 182

## 1. PLACE OF DEATH:

County

City or town

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

26 year

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 3. (a) FULL NAME

James P. Patrick

4. Sex

5. Color or race

6. Civil status, married, widowed, or divorced

Male

White Widower

6. (b) Name of husband or wife

Cladomys Patrick

7. Birth date of deceased (mo., day, yr.)

Augd 6. (c) If alive, give age years

Sept. 13 1864

8. AGE:

Years

Months

Days

If less than one day

hrs.

min.

9. Birthplace

Auree Co. Va.

(Town, county, and state)

10. Usual occupation

Farmer

11. Industry or business

Crop Farmer

MOTHER FATHER

Hilda S. Patrick

12. Name

Smith Co. Va.

13. Birthplace

Smith Co. Va.

14. Maiden name

Rachel Morrison

15. Birthplace

Smith Co. Va.

16. Informant

Mr. Donnie Patrick

Address

Darlington, Md. R.R.

17. Burial

Oct 2 1946

(Date thereof) (month) (day) (year)

(Burial, cremation, or removal? When?)

Cemetery or crematory

Mt. Zion Cem.

Location

Harford Co. Md.

18. Funeral director

A. J. Bailey

Address

Darlington Md.

19. (Date rec'd by registrar)

Sept. 30 1946

(Date)

M. J. Kirk

Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

Md

County

Harford

City or town

Marlington Rural

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

Ms

2.(a) If veteran, name war

## 3. (b) Social Security Number

No

## MEDICAL CERTIFICATION

20. DATE OF DEATH

Sept 29 1946 8<sup>30</sup>

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 12 1946 to Sept 29 1946

and that I last saw him alive on Sept 28 1946

1946

Immediate cause of death

Cerebral Hemorrhage 1 hr.

Due to

Atrial fibrillation 2 yrs

Due to

Myocarditis

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Name of Injury

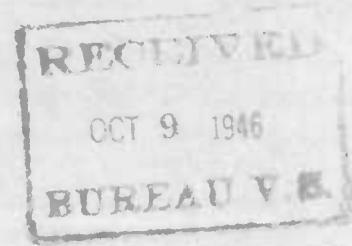
Injured at work?

23. SIGNATURE

F. J. L. Son of James

M. D. brother

Address Darlington Md Date signed 9/30/46



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

\* THIS CERTIFICATE LIMITS OF

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 159

09071

188-

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:  
 County Hagerford  
 City or town Hagerford de Grace  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 19 days  
 Hospital, Institution, or street address where death occurred:  
Hagerford Memorial Hospital  
 How long in hospital or institution? 19 days

2. USUAL RESIDENCE (HOME) OF DECEASED:  
 (For newborn infants give residence of mother)

State \_\_\_\_\_ County \_\_\_\_\_  
 City or town \_\_\_\_\_ (If outside city or town limits, write RURAL and give nearest town)  
 Street No. \_\_\_\_\_  
 (If rural, give LOCATION)

2.(a) If veteran, name war \_\_\_\_\_

## 3. (a) FULL NAME

Petaccio, Sharon Elizabeth

## 3. (b) Social Security Number

4. Sex <u>Female</u>	5. Color or race <u>White</u>	6.(a) Single, married, widowed, or divorced <u>Single</u>
----------------------	-------------------------------	---

8.(b) Name of husband or wife.....

7. Birth date of deceased (mo., day, yr.) August 22, 19468. AGE: Years 1 Months 9 Days 19 If less than one day  
hrs. \_\_\_\_\_ min. \_\_\_\_\_9. Birthplace Hagerford de Grace, Md.  
(Town, county, and state)10. Usual occupation Infant

## 11. Industry or business

12. Name Louis P. Petaccio13. Birthplace Ohio14. Maiden name Mariam B. Rollins15. Birthplace Magnolia Md16. Informant Louis P. PetaccioAddress Magnolia Md17. Burial Burnie Date thereof Sept 11 1946  
(Burial, cremation, or removal. Which?) Date (month) (day) (year)Cemetery or crematory CotterburyLocation Arlington Maryland18. Funeral director Howard K. Mortuary CorpAddress Arlington Maryland19. Date rec'd by registrar Sept 11 1946

(Date rec'd by registrar)

## MEDICAL CERTIFICATION

20. DATE OF DEATH 9/10 19 46 at 6:30 A.M.21. I certify that death occurred on the date above stated; that I attended deceased from Aug 22 1946 to Sept 10 1946, and that I last saw her alive on Sept 9 1946.

Immediate cause of death.....

Pneumonia  
Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 8 months of death)

Major findings or operations.....

Date of op. ....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of Injury.....

Injured at work?

23. SIGNATURE Dudley Phillips

D. or other

Address Hagerford Memorial Hosp signed Sept 11 1946



## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 157

89072

## CERTIFICATE OF DEATH

Reg. Dist. No. 185-

## 1. PLACE OF DEATH:

County Harford  
City or town Havre de Grace

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Harford Memorial Hospital

How long in hospital or institution?

## 3. (a) FULL NAME

Pamela  
Inabant Pinto

## 4. Sex

## 5. Color or race

## 6. (a) Single, married, widowed, or divorced

Female white

## 6. (b) Name of husband or wife

## 6. (c) If alive, give age..... years

## 7. Birth date of deceased (mo., day, yr.)

9-1-46

## 8. AGE:

Years

Months

Days

If less than one day

3 hrs. min.

9. Birthplace Havre de Grace Harford Co., Md.  
(Town, county, and state)

## 10. Usual occupation

## 11. Industry or business

12. Name George J. Pinto13. Birthplace Palisbury, Md.14. Maiden name Rebecca Patterson15. Birthplace Perryville Md.16. Informant Taylor B. PattersonAddress Perryville, Md.17. Burial Date thereof Sept. 3, 1946  
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory AshburyLocation Corp. of Ashbury, Md., Rural18. Funeral director Lee A. Patterson & SonAddress Perryville, Md.19. Date rec'd by registrar Sept. 3 1946

## (Date rec'd by registrar)

Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County OwlCity or town Perryville, Rural

Street No.

(If rural, give LOCATION)

## 2.(a) If veteran, name war

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

## 20. DATE OF DEATH

9-3 1946 at 12 A.M.

## 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Sept. 1 1946 to Sept. 3 1946  
and that I last saw her alive on Sept. 3 1946.

## Immediate cause of death

Premature  
7 months

Due to

Due to

## Other conditions

(Include pregnancy within 3 months of death)

## Major findings of operations

Date of op.

## Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

## 22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? ..... (City or town) ..... (County) ..... (State)

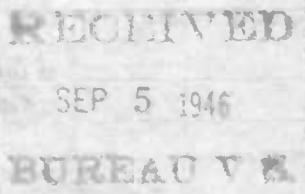
Injured at home, farm, industry, public place (where?) .....

## Means of injury

Injured at work?

## 23. SIGNATURE

B. J. Ferguson, M.D.  
M. D. or other  
Address Post Office Date signed 9-3-46  
Md.



## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 320

## CERTIFICATE OF DEATH

Reg. Dist. No. 0907381

## 1. PLACE OF DEATH

Harford County  
Aberdeen

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 74 years

Hospital, institution, or street address where death occurred

Death occurred at home

How long in hospital or institution?

## 3. (a) FULL NAME

Mrs Ella Pitt

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

female colored widowed

B.(b) Name of husband or wife...

7. Birth date of deceased (mo., day, yr.)

April 1 1872

6. (c) If alive, give age..... years

8. AGE:

Years

Months

Days

If less than one day

74

5

4

hrs.

min.

9. Birthplace

Harford County, Md.

(Town, county, and state)

10. Usual occupation

None

11. Industry or business

None

12. Name

Tyrus

W. Hymans

Burris

Harford Co. Md

13. Birthplace

—

14. Maiden name

—

15. Birthplace

—

16. Informant

Blanche Tilden

Address

49 Haynes St Aberdeen, Md

Burris

Date thereof

Sept 9 1976

(Burial, cremation, or removal. Which?)

Cemetery or crematory

cemetery

Location

Swanson Creek church

John F. Tilling

Funeral director

John F. Tilling

Address

Aberdeen

Tilling

Sept 9

1976

(Date rec'd by registrar)

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Harford

City or town Rural Aberdeen

(If outside city or town limits, write RURAL and give nearest town)

Street No. Short Lane

(If rural, give LOCATION)

2.(a) If veteran, name war None

## 3. (b) Social Security Number

My

## MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 7 1976 at M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

August 29 1976 to Sept 7 1976  
and that I last saw her alive on Sept 7 1976

Immediate cause of death

Hypertension, Ossema 1 day

Due to myocardial failure 2 days

Due to cerebral hemorrhage 10 days

&amp; hemiplegia (left)

Other conditions

Secondary hypertension -

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

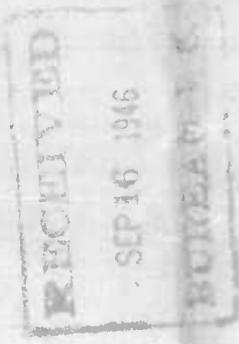
Means of injury Injured at work?

23. SIGNATURE

M. D. or other

Address

Date signed Sept 7



## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 946

## CERTIFICATE OF DEATH

Reg. Dist. No. 090741 82

## 1. PLACE OF DEATH:

County..... *Hartford*City or town..... *Harkins Shop*

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? *34 years*

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

## 3. (a) FULL NAME

*Maybell Tawney Price*

## 3. (b) Social Security Number

4. Sex

*F*

5. Color or race

*W*

6.(a) Single, married, widowed, or divorced

*M*

6.(b) Name of husband or wife

*George E Price*

7. Birth date of deceased (mo. day, yr.)

*Nov 26 - 1875*

6.(c) If alive, give age..... years

8. AGE:

Years  
*70*Months  
*9*Days  
*25*If less than one day  
hrs. .... min.

9. Birthplace

*Boring, Balto, Co., Md*

(Town, county, and state)

10. Usual occupation

*House wife*

11. Industry or business

MOTHER FATHER

12. Name..... *Andrew C Tawney**Md*

13. Birthplace

*Md*14. Maiden name..... *Agnes Taylor**Md*

15. Birthplace

16. Informant

*George E Price*

Address

*Forest Hill, Md*

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof..... *Sept 24/1946*

(month) (day) (year)

Cemetery or crematory

*Bel Air Burial Park*

Location

*Bel Air, Md*

18. Funeral director

*Dean Y Foster*

Address

*Bellair, Md*

19. Date rec'd by registrar

*9/23**1946**Priscilla Sowards*

Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH

*Sept 21 at 1946*

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

*Sept 15 1946 to Sept 21 1946*and that I last saw her alive on *Sept 21 1946*

Immediate cause of death

*Congestive heart failure 7 days*

Due to

*✓*

Due to

*✓*

Other conditions

*✓*

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? ..... (City or town) ..... (County) ..... (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

*F. P. Woodgrass*

M. D. or other

Address..... *Darlington Rd* Date signed *9/23/46*

RECV

SEP 28 1946

BUREAU V E

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 8300

09075

## CERTIFICATE OF DEATH

Reg. Dist. No. 182

## 1. PLACE OF DEATH:

County.....

City or town..... *Harford* *Arlington* *Rural*  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?.....

*72 years*

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 3. (a) FULL NAME

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

6. (b) Name of husband or wife.....

7. Birth date of

deceased (mo., day, yr.)

8. AGE:

Years      Months      Days      If less than one day  
72      2      3      hrs.      min.

9. Birthplace.....

(Town, county, and state) *Harford Co., Md.*

10. Usual occupation.....

*Housewife*

11. Industry or business

at home

12. Name.....

*Edward A. Randour*

13. Birthplace

*York Co., Penna.*

14. Maiden name.....

*Unknown*

15. Birthplace

*Mr. Elmer Randour*

16. Informant.....

Address

*Harford Co., Md.*

17. Burial

(Burial, cremation, or removal)

Date thereof..... *Sept 15 1946*  
(month) (day) (year)

Cemetery or crematory

Location

18. Funeral director.....

Address

19. (Date rec'd by registrar)

19. (Date signed)

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State.....

County..... *Md.* *Harford*City or town..... *Harford* *Arlington* *Rural*  
(If outside city or town limits, write RURAL and give nearest town)

Street No.....

(If rural, give LOCATION) *No*

2.(a) Is veteran, name war.....

## 3. (b) Social Security Number

*70*

## MEDICAL CERTIFICATION

## 20. DATE OF DEATH

*Sept 12* 1946 at 11:45 p.m.*June 20* 1946, for *Sept 12* 1946and that I last saw her alive on *Sept 12* 1946

## Immediate cause of death

*cerebral hemorrhage* DURATION *3 months*

Due to.....

Due to.....

## Other conditions

(Include pregnancy within 3 months of death)

## Major findings of operations

Date of op.

## Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

## 22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of .....

Where did injury occur? ..... (City or town) ..... (County) ..... (State)

Injured at home, farm, industry, public place (where?) .....

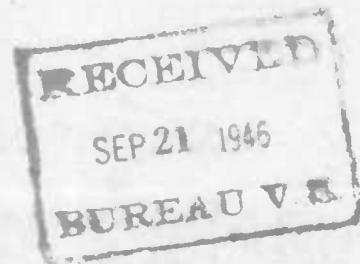
## Means of injury

Injured at work?

## 23. SIGNATURE

*M. E. Gallion* M. D. or otherAddress *Dorlingto, Md.* Date signed *9-14-46*

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 4-1515

09076

## CERTIFICATE OF DEATH

Reg. Dist. No. 182

## 1. PLACE OF DEATH:

County.....

Harford  
Forest Hill rd

City or town.....

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?.....

20 years

Hospital, institution, or street address where death occurred:

How long in hospital or institution?.....

## 3. (a) FULL NAME

Ellis Truman Reynolds

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Male white married

6. (b) Name of husband or wife.....

Bertie Reece

6. (c) If alive, give age 78 years

7. Birth date of

deceased (mo. day yr.) Feb 10 1886

8. AGE:

Years

Months

Days

If less than one day

60 7 17 hrs. min.

9. Birthplace.....

Chrome Hts Harford Co Md

(Town, county, and state)

10. Usual occupation.....

Miller

11. Industry or business

Retired

MOTHER FATHER

12. Name..... Harmon G. Reynolds

13. Birthplace.....

Lancaster Co Pa

14. Maiden name.....

Mary Emma Truman

15. Birthplace.....

Cecil Co Md

16. Informant.....

Mrs Ellis Reynolds

Address

Forest Hill rd

17. Burial

(Burial, cremation, or removal. Which?) Date thereof (month) (day) (year)

Cemetery or crematory

Wm Waters Memorial

Location

Cotown Harford Co Md

18. Funeral director.....

Martin Shultz

Address

Jarretsville Md

19. (Date reg'd by registrar)

9/28

19

Priscilla Fownd

Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State.....

Coonly.....

Harford

City or town.....

(If outside city or town limits, write RURAL and give nearest town)

Street No.....

(If rural, give LOCATION)

2.(a) If veteran, name war.....

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

20. DATE OF DEATH

Sept 27, 1946 at 10:00 AM

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from

Aug 25 1945 to Sept 27, 1946

and that I last saw him alive on Sept 27, 1946

Immediate cause of death.....

Carcinoma of Colon 18 mos

DURATION

18 mos

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations..... Carcinoma of sigmoid colon

Date of op. April 10 1946

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? ..... (City or town) (County) (State)

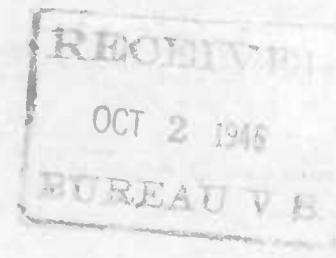
Injured at home, farm, industry, public place (where?) .....

Means of Injury

Injured at work?

23. SIGNATURE..... Willard P. Hudson M. D. or other

Address..... Forest Hill Md Date signed 9/27/46



## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 930

## CERTIFICATE OF DEATH

Reg. Dist. No.

09077 80

## 1. PLACE OF DEATH:

County... Harford  
City or town... Abingdon

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 6 month

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 3. (a) FULL NAME

Augusta Rosier

## 3. (b) Social Security Number

4. Sex

Female

5. Color or race

white

6. (a) Single, married, widowed, or divorced

widowed

6. (b) Name of husband or wife... Frank Rosier

6. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 19, 1868

8. AGE: Years 78 Months 4 Days 10 If less than one day hrs. min.

9. Birthplace... Mass U.S.A.

(Town, county, and state)

10. Usual occupation... Housewife

## 11. Industry or business

John Rosier

12. Name... John Rosier

13. Birthplace... Frances

14. Maiden name... UNKNOWN

15. Birthplace

Thomas C. Morgan

Address... Abingdon Md

17. Transportation... Date thereof... Oct 1, 1944  
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory... Tompkins-Noll Funeral Home

Location... Torrington County

18. Funeral director... Howard K. McCormick &amp; Son

Address... Abingdon Maryland

19. Oct 1, 1946 Date rec'd by registrar... Mabel M. Moulden

Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... Town... County... Litchfield

City or town... Torrington

(If outside city or town limits, write RURAL and give nearest town)

Street No... (If rural, give LOCATION)

2.(a) If veteran, name war...

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

20. DATE OF DEATH... Sept. 29 1946, at 1:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 28 1946, to Sept 29 1946,

and that I last saw her... alive on Sept 28 1946.

Immediate cause of death... Acute Heart Failure

DURATION

Due to Hypertensive cardiac vascular 0 yrs.  
disease

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

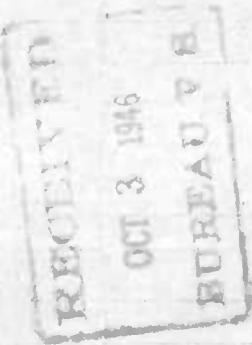
Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury..... Injured at work?

23. SIGNATURE... H.B. Gastram MD M. D. or other

Address... Aberdeen Md Date signed Oct 1



PLEASE WRITE PLAINLY, WITH  
INK. Supply every item of information carefully. The correct age  
is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 742

09078

## CERTIFICATE OF DEATH

Reg. Dist. No. 180

## 1. PLACE OF DEATH:

County..... Harford

City or town..... Joppa

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?..... 25 years

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?.....

## 3. (a) FULL NAME

Lottie Skillman

4. Sex..... 5. Color or race..... 6.(a) Single, married, widowed, or divorced

Female White Married

6.(b) Name of husband or wife..... Harry Skillman

7. Birth date of deceased (mo., day, yr.)..... 6.(c) If alive, give age ..... years

Feb. 17, 1889

8. AGE: Years Months Days If less than one day

57 7 1

9. Birthplace..... Maryland

(Town, county, and state)

10. Usual occupation..... Housewife

11. Industry or business.....

12. Name..... John M. Frasch

13. Birthplace..... Germany

14. Maiden name..... Louise Kammerer

15. Birthplace..... Maryland

16. Informant..... Harry Skillman

Address..... Joppa Md

17. Burial..... Date thereof..... Sept. 22, 1946

(Burial, cremation, or removal. Which?)

Cemetery or crematory..... Cokesbury

Location..... Abingdon Md.

18. Funeral director..... Howard K. McComas &amp; Son

Address..... Abingdon Md.

19. Date rec'd by registrar..... 1946

Name of Registrar..... Maxine M. Mouldale

Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... Maryland County..... Harford

City or town..... Joppa

(If outside city or town limits, write RURAL and give nearest town)

Street No.....

(If rural, give LOCATION)

2.(a) If veteran, name war.....

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

20. DATE OF DEATH..... Sept. 18 1946 at..... M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from  
11-4 1946 to Sept. 18 1946

and that I last saw her alive on Sept. 18 1946

Immediate cause of death..... coronary thrombosis

DURATION 1 1/2 hrs

Due to.....

Due to.....

Other conditions..... Essential hypertension

Years

(Include pregnancy within 8 months of death)

Major findings of operations..... Date of op.....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

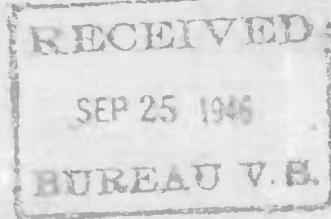
Injured at home, farm, industry, public place (where?)

Means of injury..... Injured at work?

23. SIGNATURE..... Fred O Hodson

M. D. or other

Address..... Edgewood, Md. Date signed..... 9.18-46



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 520

09079

Reg. Dist. No. 182

## CERTIFICATE OF DEATH

## 1. PLACE OF DEATH:

County

Hartford

City or town

Bel Air, Md.

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

7 years

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 3. (a) FULL NAME

Col Sydney G Smith

4. Sex

M

5. Color or race

W

6.(a) Single, married, widowed, or divorced

M

6.(b) Name of husband or wife

Winifred S. Smith

7. Birth date of deceased (mo., day, yr.)

Sept 16 - 1873

(6. c) If alive, give age years

8. AGE:

72

Years

Months

Days

If less than one day

hrs.

min.

9. Birthplace

Burgin Point, N.Y.

(Town, county, and state)

10. Usual occupation

Retired

11. Industry or business

MOTHER FATHER

John C. Smith

13. Birthplace

N.Y.

14. Maiden name

Mary B. McDonald

15. Birthplace

N.Y.

16. Informant

Mrs Winifred S. Smith

Address

Bel Air, Md.

17. Cremation

(Burial, cremation, or removal. Which?)

Date thereof Sept 16/46

(month) (day) (year)

Cemetery or crematory

London Park

Location

Baltimore, Md.

18. Funeral director

Dean &amp; Foster

Address

Bel Air, Md.

19. Date rec'd by registrar

19.

46 Priscilla Lowood

Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

Md

County

Hartford

City or town

Bel Air, Md.

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

World War I.

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

20. DATE OF DEATH

Sept 13 1946 at 9<sup>50</sup> A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Oct 1 1946 to Sept 13 1946

and that I last saw him alive on Sept 6 1946

Immediate cause of death

Coronary Thrombosis

DURATION

Sudden death

Due to

Due to

Other conditions

Molar state, carcinoma  
of bones of pelvis -

(Include pregnancy within 3 months of death)

Major findings of operations Aug 1944 - Carcinoma of  
bladder

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external cause, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Willard P. Hudson

M. D. or other

Address

Forest Hill Md

Date signed 9/13/46

RECEIVED

SEP 17 1946

BUREAU V E

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct answer is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore *(B-2)*

09080

## CERTIFICATE OF DEATH

Reg. Date No. *182*

## 1. PLACE OF DEATH:

County *Harford*  
 City or town *Ridge Bel Air*  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? *25 yrs*

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 3. (a) FULL NAME

*Samuel Allen Spicer*

4. Sex *Male* 5. Color or race *wh* 6.(a) Single, married, widowed, or divorced *Married*

6.(b) Name of husband or wife *May Edwards Spicer*7. Birth date of deceased (mo., day, yr.) *May 23, 1880*

8. AGE: Years *66* Months *4* Days *7* It less than one day  
 hrs.  min.

B. Birthplace *Alleghany Co. N.C.*

(Town, county, and state)

10. Usual occupation *Farm*

## 11. Industry or business

12. Name *Samuel Morgan Spicer*13. Birthplace *Alleghany Co. N.C.*14. Maiden name *Emma Leuder*15. Birthplace *Alleghany Co. N.C.*16. Informant *Mrs. Mary Spicer*Address *Bel Air, Md*17. Burial *Burial*

(Burial, cremation, or removal. Which?)

Date thereof *Oct 2/1846*  
 (month) (day) (year)Cemetery or crematory *Mt. Zion Cemetery*Location *Fountain Green, Harford Co., Md.*18. Funeral director *Dean & Foster*Address *Bel Air, Md*19. *10/1/46* 19. *46* Registrars  
 (Date rec'd by registrar) *Priscilla Lowwood*

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State *Md* County *Harford*  
 City or town *Ridge Bel Air*  
(If outside city or town limits, write RURAL and give nearest town)

Street No. *Wickbury*  
(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

20. DATE OF DEATH *Sept 30 1946 at 9:25 A.M.*

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from

*Sept 30 1946 to Sept 30 1946*and that I last saw him alive on *Sept 30 1946*

## Immediate cause of death

*Cerebral Hemorrhage*

## DURATION

*45 min.*

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

## Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? ..... (City or town) ..... (County) ..... (State)

Injured at home, farm, industry, public place (where?)

Means of injury

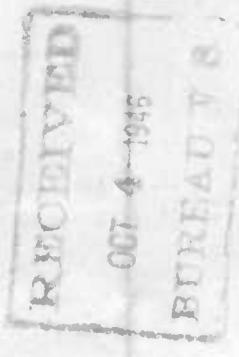
Injured at work?

23. SIGNATURE

*Willard P. Hudson*

M. D. or other

Address *Forest Hill, Md* Date signed *9/30/46*



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct cause is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

09081

185-

## CERTIFICATE OF DEATH

Reg. Dist. No.

## 1. PLACE OF DEATH:

County ..... Hanford  
 City or town ..... Hanford De Shores  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 52 yearsHospital, Institution, or street address where death occurred: Hanford Memorial HospHow long in hospital or institution? 1 day

## 3. (a) FULL NAME

Albert Stokes

## 4. Sex

## 5. Color or race

## 6. (a) Single, married, widowed, or divorced

Male Negro Married

## 6. (b) Name of husband or wife

Dorothy B. Stokes6. (c) If alive, give age ..... 38 years

## 7. Birth date of deceased (mo., day, yr.)

Dec 28 - 1893

## 8. AGE:

Years

Months

Days

If less than one day

52 8 28 ..... hrs. ..... min.

## 9. Birthplace

Maryland

(Town, county, and state)

## 10. Usual occupation

Janitor

## 11. Industry or business

Turning Thomas

## 12. Name

Mary B. Stokes

## 13. Birthplace

Maryland

## 14. Maiden name

Mary B. Stokes

## 15. Birthplace

Maryland

## 16. Informant

Dorothy B. StokesAddress 319, Strawberry Alley

## 17. Burial

Date thereof ..... 9/28/46  
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory River Creek Cem. & Col. Cen.Location River Creek Md.

## 18. Funeral director

Pennsylvania & SonAddress Hanford De Shores Md.

## 19. Date rec'd by registrar

Sept. 28 1946 A. T. Lewis M.D.  
(Date rec'd by registrar)

Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State ..... Md. County ..... Hanford

City or town ..... Hanford De Shores  
(If outside city or town limits, write RURAL and give nearest town)

Street No. 319 Street name Strawberry Alley  
(If rural, give LOCATION)

## 2.(a) If veteran, name war

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

20. DATE OF DEATH ..... 9/25 1946 at 3:30 P.M.21. I CERTIFY that death occurred on the date above stated, that I attended deceased from 9/25 1946 to 9/25 1946and that I last saw h. m. alive on 9/25 1946

## Immediate cause of death

Respiratory Failure

## Due to

P. Bronchopneumonia 1 day

## Other conditions

Pose Pearson

(Include pregnancy within 8 months of death)

## Major findings or operations

Date of op. ....

Autopsy results P. Bronchopneumonia

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of .....

Where did injury occur? ..... (City or town) ..... (County) ..... (State)

Injured at home, farm, industry, public place (where?) .....

## Means of injury

Injured at work?

## 23. SIGNATURE

Dudley Gilligan M.D.

M. D. or other

Address Hanford Mem Hosp Date signed 9/27/46

RECEIVED

SEP 30 1945

BUREAU V E

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 46

## CERTIFICATE OF DEATH

09082

Reg. Dist. No. 183

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

I

VS A15 9-45-15

1. PLACE OF DEATH:		<i>Harford</i>		
County.....		<i>Upper &amp; Roads</i>		
City or town.....		(If outside city or town limits, write RURAL and give nearest town)		
How long in above place of death?		<i>30 years</i>		
Hospital, Institution, or street address where death occurred:				
How long in hospital or institution?				
3. (a) FULL NAME		<i>Mabel Florence Walker</i>		
4. Sex	5. Color or race	8.(a) Single, married, widowed, or divorced		
<i>Female</i>	<i>white</i>	<i>married</i>		
6.(b) Name of husband or wife.....		<i>Wm H. Walker</i>		
7. Birth date of deceased (mo., day, yr.)		<i>July 15 1887</i>		
8. AGE:		Years	Months	Days
		<i>59</i>	<i>2</i>	<i>15</i>
9. Birthplace.....		<i>Rutledge Harford Md</i>		
(Town, county, and state)				
10. Usual occupation.....		<i>House wife</i>		
11. Industry or business				
12. Name.....		<i>Wm H Standford</i>		
13. Birthplace		<i>Md.</i>		
14. Maiden name.....		<i>Mary Amoss</i>		
15. Birthplace		<i>Fallston Md.</i>		
16. Informant.....		<i>Wm H Walker</i>		
Address		<i>Fallston Md.</i>		
17. Burial		Date thereof	<i>Oct 2 46</i>	
(Burial, cremation, or removal. Which?)		(month)	(day)	(year)
Cemetery or crematory		<i>Friendship</i>		
Location		<i>Fallston Md.</i>		
18. Funeral director.....		<i>Mabel S. Smith</i>		
Address		<i>Janesville Md</i>		
19. Date rec'd by registrar		<i>Oct 2 1946 Thomas P. Brown</i>		

2. USUAL RESIDENCE (HOME) OF DECEASED:	
(For newborn infants give residence of mother)	
State.....	<i>Md.</i>
County.....	<i>Harford</i>
City or town.....	
(If outside city or town limits, write RURAL and give nearest town)	
Street No.....	
(If rural, give LOCATION)	
2.(a) If veteran, name war.....	
3. (b) Social Security Number	

MEDICAL CERTIFICATION	
20. DATE OF DEATH	
<i>Sept 30 1946</i>	
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from	
<i>August 10 1946</i> to <i>Sept 25 1946</i>	
and that I last saw her alive on	
Immediate cause of death	
<i>Carcinoma of Mammary</i>	
DURATION	
<i>1946</i>	
Due to.....	
Due to.....	
Other conditions.....	
(Include pregnancy within 3 months of death)	
Major findings of operation	
<i>Carcinoma of Breast</i>	
Date of op.	
<i>Aug 1946</i>	
Autopsy results.....	
no	
PHYSICIAN: Please underline the cause to which death should be charged statistically.	
<i>Carcinoma of Breast</i>	
22. VIOLENCE: If death was due to external causes, fill in the following:	
Accident, suicide, or homicide..... Date of.....	
Where did injury occur? (City or town) (County) (State)	
Injured at home, farm, industry, public place (where?)	
Means of Injury	
Injured at work?	
23. SIGNATURE	
<i>Dalton M. Hammitt</i>	
M. D. or other	
Address.....	
<i>Baltimore</i>	
Date signed	
<i>10/1/46</i>	



## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (83-6)

09083

## CERTIFICATE OF DEATH

18

Reg. Dist. No.

## 1. PLACE OF DEATH:

County.....

Harford

City or town.....

Fallston

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?..... 81 years

Hospital, institution, or street address where death occurred:

How long in hospital or institution?.....

## 3. (a) FULL NAME

Alice King Watson

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Female

White

Single

6. (b) Name of husband or wife.....

7. Birth date of deceased (mo., day, yr.)

april 18 - 1866

6. (c) If alive, give age..... years

8. AGE:

Years  
81Months  
4Days  
27If less than one day  
hrs.  
min.

9. Birthplace.....

Fallston Harford County Md

(Town, county and state)

10. Usual occupation.....

None

11. Industry or business

12. Name.....

Rev. Thomas Watson

13. Birthplace

Baltimore, Md

14. Maiden name.....

Elizabeth Arnold

15. Birthplace

Benson Harford County Md

16. Informant.....

Miss Martha Watson

Address

Fallston. Md

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof Sept. 17 1946

(month) (day) (year)

Cemetery or crematory

Little Falls Friends Meeting House

Location

Fallston

18. Funeral director.....

Martin G. Hunt

Address

Jarretsville Md

19. (Date rec'd by registrar)

9/1/46

19

46 Rivilla Forward

Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... Md.

County.....

Harford

City or town.....

Fallston

(If outside city or town limits, write RURAL and give nearest town)

Street No.....

(If rural, give LOCATION)

2.(a) If veteran, name war.....

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

20. DATE OF DEATH September 15

19 46

at 6:35 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from September 4

19 44

to September 14 19 46

and that I last saw her alive on September 14 19 46

Immediate cause of death.....

Cerebral Thrombosis

DURATION

10 days

Due to.....

Due to.....

Other conditions..... Cerebral Arteriosclerosis

(Include pregnancy within 3 months of death)

Major findings or operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide.....

Date of.....

Where did injury occur? ..... (City or town) ..... (County) ..... (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury.....

Injured at work?

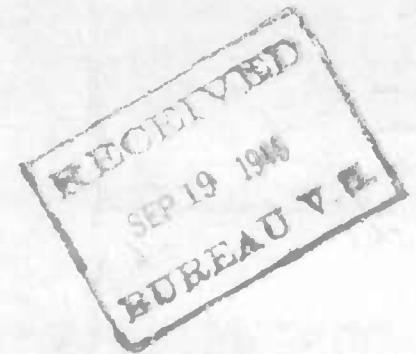
23. SIGNATURE.....

Wellard P. Hudson

M. D. or other

Address Forest Hill, Maryland.

Date signed 9/15/46



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct page  
is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 942

09084

## CERTIFICATE OF DEATH

Reg. Dist. No. 182

## 1. PLACE OF DEATH:

County.....

Hartford Co

City or town.....

Bel Air, Md

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? ✓

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

## 3. (a) FULL NAME

Lt. Sg. Louis MAXWELL WEGART

## 3. (b) Social Security Number

4. Sex

M

5. Color or race

W

6. (a) Single, married, widowed, or divorced

M

## 6. (b) Name of husband or wife

UNKNOWN

6. (c) If alive, give age..... years

## 7. Birth date of deceased (mo., day, yr.)

Jany 24 - 1882

## 8. AGE:

Years

Months

Days

If less than one day

64

8

25

hrs.

min.

## 9. Birthplace

Cleveland Ohio

(Town, county, and state)

## 10. Usual occupation

Retired-Navy

## 11. Industry or business

MOTHER FATHER

Louis M Wegart

MOTHER

UNKNOWN

FATHER

UNKNOWN

## 14. Maiden name

## 15. Birthplace

UNKNOWN

## 16. Informant

Mrs Agnes SIMPSON

Address 6046 W. Metropolitan Plaza, Los Angeles

Calif.

## 17. Burial

(Burial, cremation, or removal. Which?)

Date thereof Sept 20/46

(month) (day) (year)

Cemetery or crematory Arlington National

Location Arlington Va.

## 18. Funeral director

Address

Dean &amp; Laster

Bellair, Md

## 19. Date rec'd by registrar

19 46

Biscilla Lowndes

Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State.....

Md Pa

County.....

Chester

City or town.....

(If outside city or town limits, write RURAL and give nearest town)

Street No.....

(If rural, give LOCATION)

2.(a) If veteran, name war

World War I

## MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 18, 1946

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19..... to..... 19.....

19.....

and that I last saw h..... alive on.....

Immediate cause of death.....

Coronary Occlusion

DURATION

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings at operation.....

Date of op. ....

Autopsy results.....

None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide.....

Date of.....

Where did injury occur? .....

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?) .....

Means of injury.....

Injured at work? .....

23. SIGNATURE.....

J. H. Hanney M.D.  
Department Examiner  
Aberdeen, Md. Date signed 9/15/46

Address.....



## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

09085

183

## CERTIFICATE OF DEATH

Reg. Dist. No.

## 1. PLACE OF DEATH:

County

Harford

City or town

Janesville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

36 years

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 3. (a) FULL NAME

4. Sex

5. Color or race

6.(a) Single, married, widowed, or divorced

male

white

married

6.(b) Name of husband or wife

Angelice R. Bowman

7. Birth date of deceased (mo., day, yr.)

March 17 - 1871

6.(c) If alive, give age 64 years

8. AGE:

Years

Months

Days

If less than one day

75

6

1

hrs.

min.

9. Birthplace

Janesville Harford Co Md

(Town, county, and state)

10. Usual occupation

Farmer

11. Industry or business

Jeromiah Whittle

12. Name

not known

MOTHER FATHER

13. Birthplace

Ellen Monroe

14. Maiden name

not known

15. Birthplace

not known

16. Informant

Angelina R. Whittle

Address

Janesville Md.

17. Cemetery or crematory

Burrial Date thereof Sept 21 1946

(Burrial, cremation, or removal. Which?)

(month) (day) (year)

Location

Coftown Harford Co Md.

18. Funeral director

Martha Smith

Address

Janesville Md.

19. Date rec'd by registrar

Sept 21 1946 Thomas R. Brown

(Date rec'd by registrar)

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

Md

County

Harford

City or town

Janesville Co

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

2D. DATE OF DEATH

Sept 18 1946 at 11:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

September 1945 to Sept. 18, 1946,

and that I last saw h.l.v. alive on Sept. 16, 1946.

Immediate cause of death Pulmonary tuberculosis.

Duration 6 mo.

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings or operations None

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE

Charles O. Hoff M.D. or other

Address Street, Md. Date signed 10/19/46

9-19-46



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 159

## CERTIFICATE OF DEATH

09086

Reg. Dist. No. 182

## 1. PLACE OF DEATH:

County.....

Harford

City or town.....

Fountain Green

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 3. (a) FULL NAME

MELVIN ROE WILLIAMS

4. Sex

W

5. Color or race

6.(a) Single, married, widowed, or divorced

S

6.(b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.)

SEPT. 3, 1946

6.(c) If alive, give age ..... years

8. AGE:

Years

Months

Days

If less than one day

4

hrs.

min.

9. Birthplace

Fountain Green

(Town, county, and state)

10. Usual occupation.

11. Industry or business

FATHER

12. Name..... MELVIN BROWN

13. Birthplace

W. Va

MOTHER

14. Maiden name..... VIRGINIA WILLIAMS

15. Birthplace

W. Va

16. Informant

Mrs. Zelma Williams

Address

Street MD

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof.....

Sept 7/1946  
(month) (day) (year)

Cemetery or crematory.....

Mt Zion

Location.....

Forest Green

Dean &amp; Foster

18. Funeral director.....

Address

Bel Air Md

19. Date rec'd by registrar

19

46

(Date rec'd by registrar)

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State.....

Md

County.....

Harford

City or town.....

Forest Green

(If outside city or town limits, write RURAL and give nearest town)

Street No.....

(If rural, give LOCATION)

2.(a) If veteran, name war.....

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

## 20. DATE OF DEATH

6 SEPTEMBER 1946 at 820 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

2 SEPT.

1946

to 6 SEPT.

1946

and that I last saw h.s.a. alive on 6 SEPT.

1946

Immediate cause of death.....

PREMATURITY

DURATION

4 DAYS

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.

Autopsy results..... NO

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide.....

Date of.....

Where did injury occur?.....

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?).....

Means of injury.....

Injured at work?

23. SIGNATURE

Robert A Barthol MD

M. D. or other

Address..... Forest Hill Md

Date signed..... 9/7/46

RECEIVED

SEP 10 1968.

BUREAU V E

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. U-181

## 1. PLACE OF DEATH:

HARFORD  
County.....  
City or town..... ABERDEEN PROVING GROUND  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

STATION HOSPITAL, ABERDEEN PROVING GROUND

How long in hospital or institution?

## 3. (a) FULL NAME

FERDINAND F. WOLF

## 4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

MALE

WHITE

SINGLE

6. (b) Name of husband or wife..... None

## 7. Birth date of deceased (mo., day, yr.)

11 NOVEMBER 1918

8. (c) If alive, give age..... years

## 8. AGE:

Years

Months

Days

If less than one day

27

10

16

hrs.

min.

9. Birthplace..... CUYAHOGA, OHIO

(Town, county, and state)

## 10. Usual occupation..... SOLDIER

## 11. Industry or business

CONRAD WOLF

12. Name..... CONRAD WOLF

13. Birthplace..... Unknown

14. Maiden name..... Unknown

15. Birthplace.....

## 16. Informant.....

HEADQUARTERS, ORD. TRAINING CENTER

Address

ABERDEEN PROVING GROUND, MARYLAND

17. Transportation.....

(Burial, cremation, or removal. Which?)

Date thereof..... Sept 30 1946

(Month) (day) (year)

Cemetery or crematory.....

Mourning Vogt Funeral Home

Location..... Alliance Ohio

## 18. Funeral director.....

Howard K. McCormick

Address

Abingdon Maryland

Oct. 3 1946

Nellie K. Riley

(Date rec'd by registrar)

Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... OHIO

County.....

SALEM

(If outside city or town limits, write RURAL and give nearest town)

Street No. RFD # 1

(If rural, give LOCATION)

2.(a) If veteran, name war. WORLD WAR II

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

20. DATE OF DEATH..... 27 SEPT/BER 1946 at 5:35 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19..... to..... 19.....

and that I last saw h..... alive on.....

Immediate cause of death..... LOBAR PNEUMONIA

DURATION

Due to..... LYMPHOMA OF STOMACH, LUNGS,

PLEURA, SPLEEN, PANCREAS

Due to.....

Other conditions..... ANEMIA, SECONDARY

(Include pregnancy within 8 months of death)

Major findings of operations.....

Date of op.

Autopsy results..... LYMPHOMA, AS ABOVE

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town)..... (County)..... (State).....

Injured at home, farm, industry, public place (where?).....

Means of injury.....

Injured at work?

23. SIGNATURE..... B. H. Landis 1244, M.C.

M. D. or other

Address..... Date signed.....

OPTIONAL FORM NO. 10  
MAY 1962 EDITION  
GSA GEN. REG. NO. 27  
FEDERAL GOVERNMENT PRINTING OFFICE: 1962 1410-100

